Children's REHAB CENTER

General Information				Date________________
Patient Name	Nickname	Gender ❑ M ❑ F	Birthdate__/__/___	Age
Mother's Name		Father's Name		
Who does the child live with?				
If child does not live with parents, how does child refer to caregiver (Ex: grandma, grandpa, etc.)?				

Is child adopted?	❑ Y	❑ N	If yes, at what age was child placed with this family?
Is child in foster care?	❑ Y	❑ N	If yes, at what age was child placed with this family?
Languages spoken in home:			
Preferred language of primary caregiver for instructional materials:			

List ALL patient medications currently taking and reason	Sibling's Names	Age	Gender	
			❑ M	❑ F
			❑ M	❑ F
			❑ M	❑ F
			❑ M	❑ F
			❑ M	❑ F

Describe reason for evaluation and areas of concern:
Pregnancy and Birth History
List any complications, illnesses, injuries, hospitalizations, bleeding, or fetal drug/alcohol exposure during this pregnancy:
Gestational age or list due date:

Delivery	❑ Vaginal ❑ suction/vacuum ❑ forceps ❑ none	❑ C-section ❑ planned ❑ unplanned ❑ emergency

Birth Weight:	Length:	Apgar score:

Was child born blue?	❑ Y	❑ N	Was cord around neck?	❑ Y How many times:	❑ N

Oxygen or respiratory assistance	❑ Y Type and for how long:	❑ N
Length of hospital stay:		
NICU	❑ Y Number of days spent in NICU:	❑ N
❑ Breast-fed	❑ Bottle-fed Formula:	❑ Both
Describe any feeding difficulties including latching, sucking, reflux/GERD, sensitivities, etc.:		

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School History				
School Name:			Grade:	
Services child receives through school or Early Developmental Network (check all that apply)	❑ physical therapy	❑ occupational therapy	❑ speech therapy	❑ other:

Describe child's performance in school	Strengths:	Weaknesses:

Describe any behaviors at home or school that concern you:

Medical History						
Has your child ever had any of the following:			Comments (specify condition, specialists following care, dates, etc):			
Heart conditions	❑ Y	❑ N				
Respiratory conditions	❑ Y	❑ N				
Seizures	❑ Y	❑ N				
Frequent ear infections	❑ Y	❑ N	Tubes in ears	❑ Y	❑ N	
Chicken pox	❑ Y	❑ N				
Fevers over 101 degrees	❑ Y	❑ N				
Excessive vomiting or reflux	❑ Y	❑ N				
Latex allergy	❑ Y	❑ N				
Food allergies	❑ Y	❑ N				
Other allergies	❑ Y	❑ N				
Asthma	❑ Y	❑ N				
Hearing problems	❑ Y	❑ N				
Wears hearing aids	❑ Y	❑ N				
Vision problems	❑ Y	❑ N				
Wears glasses or corrective lenses	❑ Y	❑ N				
Fallen and hit head	❑ Y	❑ N				
Knocked unconscious	❑ Y	❑ N				
Been intubated	❑ Y	❑ N				
Feeding tube (NG tube, G-button, PEG tube, etc.)	❑ Y	❑ N				

Most recent eye exam	Date:
Most recent physical/well-check	Date:
Special tests (hearing test, swallow study, x-ray, CT scan, MRI, ultrasound, genetics, etc.)	Date(s), reason(s), & results:
Hospitalizations	Date(s) & reason(s):
Surgeries	Date(s) & type(s):

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Upcoming medical appointments, follow-ups, surgeries	Date(s) & type(s):			
Current restrictions by doctor				
Previous outpatient therapy	Speech	❑ This clinic	❑ Other	Date & reason:
	OT	❑ This clinic	❑ Other	Date & reason:
	PT	❑ This clinic	❑ Other	Date & reason:

Additional medical information not otherwise mentioned:
Medical/therapy equipment used by child (braces, standers, wheelchairs, adaptive equipment, switches, communication devices etc.)

Does your child enjoy movement?	❑ Y	❑ N	Was your child a fussy baby?	❑ Y	❑ N

Describe any recent loss of function due to illness or injury:

Growth and Development	
List age child was able to:	
Roll over and over	Completely toilet trained
Pivot on tummy	Speak first real words
Sit alone	Speak first real sentences
Crawl on hands and knees	Brush teeth
Stand alone	Feed self finger foods
Walk without help	Feed self with utensils

Preferred hand (hand dominance):	❑ Right	❑ Left	❑ Unsure	Age began showing preference:

Developmental Milestones for Dressing/Undressing (Skip this section if child is under 1 year)					
If over 1 year, can your child independently:					
Remove socks	❑ Y	❑ N	Put on pants, shorts, skirts	❑ Y	❑ N
Untie shoe bow	❑ Y	❑ N	Put on shoes	❑ Y	❑ N
Remove shoes	❑ Y	❑ N	Lace Shoes	❑ Y	❑ N
Remove pants, shorts, skirts	❑ Y	❑ N	Put on pull-over shirt	❑ Y	❑ N
Remove pull-over shirt	❑ Y	❑ N	Tie shoe bow	❑ Y	❑ N
Put on socks	❑ Y	❑ N			
Fasteners:					
Unbutton	❑ Y	❑ N	Buckle	❑ Y	❑ N
Unzip separating zipper	❑ Y	❑ N	Insert belt into loops	❑ Y	❑ N
Unbuckle	❑ Y	❑ N	Snap front	❑ Y	❑ N
Fasten front button	❑ Y	❑ N	Zip separating zipper	❑ Y	❑ N

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Communication History					
Does your child show any of the following:					
Communication difficulty or trouble expressing wants/needs	❑ Y	❑ N	Frustration with communication	❑ Y	❑ N
Describe:			Describe:		
Understands when you talk to him/her	❑ Y	❑ N	Have tantrums due to speech frustration	❑ Y	❑ N
Family members understand language spoken	❑ Y	❑ N	Communication interferes with peer interaction	❑ Y	❑ N
Imitates sounds	❑ Y	❑ N	Follows simple directions	❑ Y	❑ N
Imitates words	❑ Y	❑ N	Answers yes/no questions	❑ Y	❑ N
Imitates phrases	❑ Y	❑ N	Uses sign language	❑ Y	❑ N

At what level does he/she communicate most effectively? (choose one)				
❑ Gestures only	❑ Gestures and babbling/nonsense words	❑ Gestures with a few words	❑ Single words	❑ Short phrases (2-4 words)

How much of his/her speech can you understand?			
❑ <25%	❑ 25-50%	❑ 50-75%	❑ 100%

List words used consistently:
How many total words does he/she has:
List signs used consistently:
How many total signs does he/she use:

Which does he/she identify by pointing to? (check all that apply)			
❑ Objects	❑ Pictures	❑ Body parts	❑ Family members

How does he/she protest?
How does he/she request something from you?

Oral Motor/Sensory Issues
Describe current diet:

My child currently eats: (check all that apply)				
❑ Formula Type/Brand:	❑ Baby food Stage:	❑ Pureed food	❑ Soft foods	❑ Regular diet

Does your child currently or has your child ever required thickened liquids?	❑ Y	❑ N

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Does your child show any of the following:			Comments:	
Difficulty sucking or swallowing as an infant	❑ Y	❑ N		
Allow tooth brushing without a struggle	❑ Y	❑ N		
Use a pacifier	❑ Y	❑ N		
Suck thumb or finger	❑ Y	❑ N		
Mouth toys for exploration	❑ Y	❑ N		
Drooling	❑ Y	❑ N		
Picky eater	❑ Y	❑ N	Preferred foods:	Foods avoided:
Gag, choke, vomit with meals	❑ Y	❑ N	Specific trigger if known (sight, smell, consistency/texture, specific foods, etc.):	
Ever been on reflux medication	❑ Y	❑ N		
Unusual fears for his/her age	❑ Y	❑ N		
Normal sleep/wake patterns	❑ Y	❑ N		
Excessively bothered by noise, light, or sensation	❑ Y	❑ N		
Get so upset you are unable to comfort	❑ Y	❑ N		
Able to calm self	❑ Y	❑ N		
Engages in constructive play (puzzles, blocks, etc.)	❑ Y	❑ N		
Pretend plays	❑ Y	❑ N		
Loses bowel and/or bladder control during daytime	❑ Y	❑ N	How often:	
			How much (streaking, full bowel movement, underwear damp, bed soaked etc.):	
			When (playing, angry or upset, on way to toilet, just after using toilet, after being corrected, etc):	
Loses bowel and/or bladder control during nighttime	❑ Y	❑ N	How often:	
			How much (streaking, full bowel movement, underwear damp, bed soaked etc.):	
Describe any unusual reactions to dressing, bathing, etc.:				
Easiest way to comfort child:				
Favorite toy/character:				
Activity he/she would enjoy when you have 30 minutes to spend together:				